EPI-LOG

Communicable Disease and Epidemiology News
Published continuously since 1961
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Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.
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Return Services Requested

Vol. 43, No. 3 **March 2003**

Severe Acute Respiratory Syndrome (SARS) in Travelers to Asia

An outbreak of a newly recognized disease named Severe Acute Respiratory Syndrome (SARS) has been described in travelers to Hong Kong and Guangdong, China; and Hanoi, Vietnam. Travel-related SARS cases have also been reported from Canada, Indonesia, Philippines, Singapore, and Thailand. Preliminary reports have not positively identified the etiologic agent. Early symptoms have included influenza-like symptoms such as fever, myalgias, headache, sore throat, dry cough, shortness of breath, or difficulty breathing. In some cases these symptoms are followed by hypoxia, pneumonia, and, occasionally, acute respiratory distress (requiring mechanical ventilation), and death. Laboratory findings may include thrombocytopenia and leukopenia. The infection appears to spread through close contact with cases. Secondary infections have primarily occurred among health care workers caring for the ill patients and household contacts of ill patients. The epidemiology of the outbreak suggests droplet transmission is the main route of spread, with potential airborne transmission.

Public Health is requesting King County health care providers report cases meeting the **current Centers for Disease Control and Prevention (CDC) case definition for suspect SARS:**

Respiratory illness of unknown etiology with onset since February 1, 2003, and the following criteria:

- *Measured* temperature >100.4 °F (>38° C)
- One or more clinical findings of respiratory illness (e.g. cough, shortness of breath, difficulty breathing, hypoxia, or radiographic findings of either pneumonia or acute respiratory distress syndrome)
- Travel within 10 days of onset of symptoms to an area with suspected or documented community transmission of SARS (Hong Kong and Guangdong province, China; Hanoi, Vietnam; and Singapore)

  OR
- Close contact* within 10 days of onset of symptoms with either a person with a respiratory illness and travel to a SARS area or a person under investigation or suspected of having SARS.

*Close contact is defined as having cared for, having lived with, or having had direct contact with respiratory secretions and /or body fluids of a patient suspected of having SARS.

Infection control recommendations from CDC
Outpatient: Potential SARS patients should be evaluated promptly in a separate assessment area to determine if they meet the case definition for suspect SARS and require isolation. A surgical mask should be placed on the patient if possible. All health care personnel should wear N-95 respirators while taking care of patients with suspected SARS. Precautions should be used when evaluating or transporting patients or in any ambulatory healthcare setting. If N-95 respirators are not available, surgical masks should be worn.
Inpatient: standard precautions with eye protection, contact precautions, and airborne precautions (negative pressure isolation room and n-95 or higher respirators for persons entering the room. See CDC web site for complete details.

Please check the CDC website at www.cdc.gov frequently for information on:

- Travel advisories
- Updated case definitions, areas affected by SARS, infection control, diagnostic evaluation, and treatment.

Links to current information in SARS will also be available at the Public Health website, www.metrokc.gov/health

Report cases of suspect SARS to Public Health at our 24/7 communicable disease number: (206) 296-4774.

New Recommendations for Interpreting and Reporting Results of Antibody to Hepatitis C Virus

Until recently, supplemental testing was required to confirm whether persons who tested positive for anti-Hepatitis C virus (HCV) antibodies (anti-HCV) using a screening immunoassay (EIA) were truly infected with HCV because false positives (especially among populations with a low prevalence of HCV infection) are common. In a low risk population, the average false positive rate is 35%, and ranges from 15 to 60%. Hence, supplemental testing by either recombinant immunoblot assay (RIBA), or qualitative or quantitative HCV RNA was required before HCV infection could be confirmed.

Because 1) most laboratories do not automatically confirm a positive anti-HCV screening test by RIBA or HCV RNA, 2) some laboratories don't have the capacity to do supplemental testing, and 3) there are special specimen handling requirements for HCV RNA testing, the Centers for Disease Control and Prevention (CDC)

recently introduced a method for identifying HCV screen positives that are likely to be true positives by using the signal-to-cutoff (s/co) ratio of the HCV screening test results.

Using the new guidelines, if the s/co ratio is >3.8, the case can be considered a confirmed HCV infection. If the s/co ratio is <3.8, more specific testing should be performed to confirm the diagnosis of hepatitis C (RIBA or HCV RNA). To distinguish between a current and past HCV infection, an HCV RNA must still be performed. CDC is currently working with laboratories to implement the new recommendations, which include automatically performing and reporting the result of the s/co ratio for every anti-HCV EIA. For questions about how individual laboratories are planning to handle this, please contact the laboratory directly.

Beginning with this issue, the Hepatitis C (chronic, confirmed/probable) category includes cases with HCV screening test results with a s/co >3.8.

The recommendations, "Guidelines for Laboratory Testing and Result Reporting of Antibody to Hepatitis C Virus," MMWR, February 7, 2003/52(RR03); 1-16, are available online at:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5203a1.htm

For questions on testing and reporting of hepatitis cases, please contact Sandra Randels at (206) 205-5808.

Update-*Salmonella* Enteritidis Outbreak associated with Egg Consumption in Washington State

Isolates from 34 Washington State cases of *Salmonella* Enteritidis infection have an indistinguishable pattern by Pulsed Field Gel Electrophoresis (PFGE) testing. Cases are primarily from King (N = 10) and Snohomish (N = 20) Counties. Reports of cases associated with this outbreak began in late December, 2002, and reports of new cases of *S.* Enteritidis in Washington State have dropped dramatically since the end of January 2003. Based on the results of a case-control study conducted by Washington State Department of Health (DOH), eggs are the likely source of the outbreak. A number of cases reported consuming undercooked or raw eggs, but others reported consuming fully cooked eggs. The Food and Drug Administration (FDA) has been notified of the results of the case control study and is conducting a traceback of implicated eggs.

To help with this ongoing investigation, please obtain stool specimens for bacterial culture from persons with symptoms compatible with salmonellosis (sudden onset of diarrhea, abdominal cramps, fever, and sometimes vomiting), and report any suspected or confirmed cases to public health promptly.

People at high risk for serious complications of salmonella infection (the very young, the elderly, and persons with compromised immune systems) should be particularly careful not to consume foods containing raw eggs (e.g., Caesar salad dressing, raw cookie dough) and should consume only egg dishes which are completely cooked. Information on salmonellosis is available online at: **www.metrokc.gov/health/prevcont/salmon.htm**

Influenza Update

Through the week ending March 8, 2003 the Public Health-Seattle & King County laboratory has tested 119 specimens submitted by sentinel physicians and has reported seven influenza A (H3N2), eighteen influenza A (H1), and three influenza B isolates. Additionally, the lab reported one adenovirus, one parainfluenza type 2, one parainfluenza type 3, two respiratory syncytial virus, and two coxsackie B virus isolates. The week of March 10-14, the number of schools reporting 10% or more absenteeism rose sharply to 14, with all grade levels and all parts of King County represented. No nursing home influenza outbreaks have been confirmed.

Reminder: In King County, please report all smallpox vaccine adverse events to: (206) 296-4774

Disease Reporting

AIDS/HIV	(206) 296-4645
STDs	(206) 731-3954
TB	(206) 731-4579
Other Communicable Diseases	(206) 296-4774
Automated 24-hr reporting line for conditions not immediately notifiable	(206) 296-4782

Hotlines:

Communicable Disease	(206) 296-4949
HIV/STD	(206) 205-STDS

***EPI-LOG* Online: www.metrokc.gov/health/providers**

Reported Cases of Selected Diseases, Seattle & King County 2003

	Cases Reported in February		Cases Reported Through February	
	2003	2002	2003	2002
Campylobacteriosis	18	14	34	39
Cryptosporidiosis	2	1	4	4
Chlamydial infections	328	378	696	698
Enterohemorrhagic *E. coli* (non-O157)	0	0	0	0
***E. coli* O157: H7**	4	1	6	1
Giardiasis	4	13	17	37
Gonorrhea	96	139	225	257
***Haemophilus influenzae* (cases <6 years of age)**	0	0	0	0
Hepatitis A	1	4	3	11
Hepatitis B (acute)	2	4	5	5
Hepatitis B (chronic)	49	38	103	67
Hepatitis C (acute)	2	0	2	3
Hepatitis C (chronic, confirmed/probable)	101	148	220	313
Hepatitis C (chronic, possible)	28	28	53	83
Herpes, genital (primary)	52	65	112	123
HIV and AIDS (includes only AIDS cases not previously reported as HIV)	53	53	89	108
Measles	0	0	0	0
Meningococcal Disease	0	1	1	4
Mumps	0	0	0	0
Pertussis	11	7	37	12
Rubella	0	0	0	0
Rubella, congenital	0	0	0	0
Salmonellosis	11	10	35	19
Shigellosis	8	6	16	8
Syphilis	5	3	7	8
Syphilis, congenital	0	0	0	0
Syphilis, late	6	2	8	4
Tuberculosis	15	2	28	11

The *Epi-Log* is available in alternate formats upon request.

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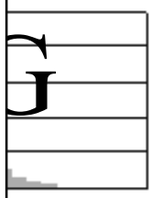

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